(De)constructing Body Image

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Abstract

The reification of body image leads to unarticulated ideological and conceptual assumptions that obscure the most dynamic and productive features of the construct. These assumptions are that body image: (1) 'exists'; (2) is a socially mediated product of perception; (3) is 'internal' and 'of the individual'; (4) can be treated and measured as if real; and (5) individuals' respond to body image measures as if neutrally providing information about pre-existing images held in their heads. We argue that it is more useful to consider body imaging as a process, an activity rather than a product.

Keywords

- *body*
- *construct*
- *critical*
- *image*
- *measures*

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BODY IMAGE HAS been a powerful central concept for health psychologists. In particular, possible links have been explored between body dissatisfaction and unhealthy weight control behaviours such as disordered or restricted eating (e.g. Connor, Johnson, & Grogan, 2002; Story, French, Resnick, & Blum, 1995) or smoking (e.g. Jeffrey, Hennrikus, Lando, Murray, & Lui, 2000); the uptake, or not, of exercise and activity programmes (e.g. Furnham & Greaves, 1994; Grogan, 1999); drug use including the abuse of anabolic steroids and over-the-counter medicines such as diuretics (e.g. Blouin & Goldfield, 1995; Wright, Grogan, & Hunter, 2000); depression and self-esteem (e.g. Holson, Kraft, & Roysamb, 2001; Tiggemann & Wilson-Barrett, 1998); and distress and coping in relation to bodily changes in pregnancy, chronic illness and surgery (e.g. Rumsey & Harcourt, 2005).

Body image is usually described theoretically in terms of complexity and multi-dimensionality, and as a conscious and unconscious human experience informed by historical, cultural, social, individual and biological factors (e.g. Taleporas & McCabe, 2002). In research it is treated as a reified, relatively fixed schema, which exerts influence upon people's behaviour. This simplistic notion of body image is not central in the theory but it is the core assumption that underpins research that attempts to reveal the impact body image has upon health-related behaviour. This article sets out to elaborate the assumptions that we feel underpin the use of body image, to explore their consequences and consider what might be achieved if these assumptions were made more explicit and further research questions opened up. This article does not offer an exhaustive overview of research in body image (for this we direct readers elsewhere, e.g. Cash & Pruzinsky, 2002). Rather our aim is to outline key features of the corpus of body image literature to show the ways in which these obscure the dynamic, agentic and productive features of the individual's engagement with the body.

Although this article focuses a great deal on methodology because we look at what health psychologists do when they study body image, it does not present a methodological critique. The purpose of the article is to show, by focusing on research, how five implicit assumptions underpin the way in which body image is conceptualized, and how these assumptions narrow the focus of research. We argue that despite rhetoric about the complex and multidimensional nature of body image, these assumptions create a simplistic and fixed model of body image. This model may be fit for the purposes and research questions typically addressed in health psychology, but it limits the usefulness of the body image construct and prevents us addressing wider research questions.

Assumptions underpinning body image research

Assumption 1: body image 'exists'

'Body image' is a hypothetical construct, much like the term 'attitude', invented by psychologists to explain patterns in behaviour and psychological phenomena (similar criticism has been made of attitude research, see Potter & Wetherell, 1987). Current thinking assumes that although people may not have an 'accurate' image of their body, it is axiomatic that they have an image and use it in thinking about their bodies and in guiding their embodied behaviour. Accordingly, a 'body image' exists in the mind of the individual even before they engage as research participants.

The term 'body image' was originally defined by Paul Schilder in the 1920s as, 'the picture of our own body which we form in our mind, that is to say, the way in which the body appears to ourselves' (1950, p. 11). The concept has since been expanded to include both perceptions and attitudes. Rudd and Lennon define body image as:

> the mental image we hold of our bodies. The perceptual component refers to how we 'see' our size, shape, weight, features, movement, and performance, while the attitudinal component refers to how we feel about these attributes and how our feelings direct our behaviours. (2000, p. 153)

Health psychologists had good reason to suggest that people carry within them a mental schema for representing their beliefs, attitudes, feelings and perceptions about their bodies. Such a schema might help to explain why people hold discrepant views about their physical needs and

their physical condition. For example, research addressing anorexia nervosa could potentially reconcile the apparently nonsensical finding that extremely thin people are motivated to maintain and exacerbate that thinness, if one understood that such people held an erroneous 'body image' which did not accurately reflect their painfully thin form. As an explanatory framework, 'body image' follows a long tradition in psychology of using constructs, such as 'attitude', to explain links between a range of diverse behaviours which might otherwise appear to be unconnected.

Both body image researchers and the general public now talk as if 'body image' was a (potentially problematic) entity that individuals possess and which might influence their behaviours and mental (ill)health. Discussion of 'body image' in the media—including coverage of problematic body image and eating disorders, moral panics about the use of 'skinny' models to advertise products and concern about girls' apparent susceptibility to such images—draw on assumptions that people have a 'body image' and that it may be dysfunctional. However, 'body image' is a hypothetical construct, and as such it is only one plausible explanation for observable phenomena.

Assumption 2: body image is a (socially mediated) product of perception

The schema-based model of body image common in health psychology conceptualizes body image as a product of perception—as constructed through a process in which we perceive our own bodies and other people's bodies, make comparisons and internalize these comparisons and alter our body image in the light of such comparisons. Initially, perceptual processes were conceived rather narrowly in terms of the ways in which visual information about the body was processed. This interest in perceptions of the body, and specifically perceptual distortion, was driven by the investigation of clinical disorders. For example, in the 1960s, Bruch (1962) suggested that anorexic women show a marked distortion in their perception of their body size—they perceived themselves to be fat even when they are painfully and dangerously underweight. Following this, Slade and Russell's (1973) widely cited and hugely influential studies of body perception using the 'moveable calliper technique' provided the methodological template for much of the research that followed. This technique provided an apparently objective and reliable measure of body distortion that enabled participants accurately to estimate their body dimensions. Using this method, participants adjust four projected light beams until the projected image matches their perception of the width of their own body at particular points (typically the cheeks, hips, waist and thighs). Any discrepancy between the objective measurements and the participants' estimate of their own body shape is taken as an indicator of the individuals' perceptual distortion of their own image. Slade and Russell's findings that individuals with Anorexia Nervosa overestimated the size of their body spurned a flurry of related empirical research and theorizing. However, the technique raises a number of methodological problems and provides mixed empirical findings. For example, size estimation and subjective dissatisfaction with body shape have not been found to be highly correlated, and the perceptual component—previously assumed to be a 'static and rather unmalleable aspect of body image' has been found to be 'affected by numerous contextual factors' (Thompson & Gardner, 2002, p. 137). But, the assumption remains, however implicitly, that individuals would be able to see their bodies accurately if there were no cultural or psychic pressures to distort their vision. Although new technological advances which purport to separate the sensory (the responses of the visual system), from the non-sensory (the brain's *interpretation* of the visual output), aspects of perception have attracted renewed interest (see Thompson & Gardner, 2002, for an overview), there has been a shift of interest away from theorizing perceptual distortion in favour of exploring subjective dissatisfaction. Despite this shift, the assumption that body image is a perceptual phenomenon permeates a range of other current approaches (including silhouette comparison studies which are discussed later).

The waning of interest in the visual perception of the body marked a shift towards measuring subjective satisfaction with the appearance of the body. Rather than focusing on the discrepancy between the individual's *actual* and perceived body size/shape, researchers are

exploring the discrepancy between individuals' perceived and *ideal* body size/shape. Such a shift acknowledges that one's perception and evaluation of one's own body takes place in a cultural context in which some bodies (e.g. thin, white, symmetrical and unblemished) are more highly socially valued than others. Many studies continue to adopt the same methodological techniques but the focus is on body (dis)satisfaction rather than body image distortion, with, for example, people asked to indicate which of a set of line-drawn silhouettes best represents their current and ideal figure. The discrepancy between the figures chosen is taken as a measure of their level of body dissatisfaction. This method has consistently shown that most women choose as 'ideal' a thinner body than their own (Altabe & Thompson, 1993; Fallon & Rozin, 1985; Lamb, Jackson, Cassidy, & Priest, 1993), and is as Grogan observes 'one of the most widely used quantitative measures of degree and direction of body dissatisfaction' (1999, p. 26). Although described as a measure of body image attitudes rather than perception, this technique is implicitly about perception. In recognizing that 'ideal' body image is socially shared rather than the unique and idiosyncratic production of the individual, health psychology recognizes and incorporates cultural context. Despite this, body image is, like other schema, conceptualized as a self-adjusting pocket of information, vulnerable to distortion by culturally influenced perceptual practices, but ideally and potentially a more or less accurate mental representation of the individual's body.

Assumption 3: body image is 'internal' and therefore 'of the individual'

The model of body image often employed by health psychologists is one that rests within the individual, reinforcing the notion that body image is an individual possession. Although recent research in health psychology has made some attempt to address the fact that the individual operates within a social context, typically social and cultural phenomena are seen as forces operating upon the individual in order to alter their internal mental representation of the body.

For example, treating 'ideal' body image as socially shared rather than idiosyncratic has encouraged examination of the role of cultural standards of beauty in the individual's perceptions of, and satisfaction with, their own body (often referred to as the socio-cultural theory). Particular attention is paid to the role of the media in communicating and promoting these cultural standards. Content analyses of the size and shape of men and women represented in the media consistently show that representations of women have become thinner (Silverstein, Purdue, Peterson, & Kelly, 1986) and representations of men have become more muscular (Leit, Pope, & Grey, 2001). These media representations appear to give an explanation for increasing rates of eating disorders, body dysmorphia and body dissatisfaction to researchers and lay people alike. Researchers eager to explore the effects of these media images have often opted for experimental research in which young people and, in particular, young women are exposed to media imagery of thin models and the effects on their attitudes, beliefs and behaviour are studied and measured. Results of such studies often demonstrate that women become more dissatisfied with their appearance after viewing such images (e.g. Groesz, Levine, & Murnen, 2002; Hargreaves & Tiggeman, 2002). Although the socio-cultural theory of body image disturbance is the most empirically validated of all body image theories (Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999), the mechanisms by which media representations influence body image are not well understood. One suggestion is that media images provide a reference point for social comparison. Myers and Biocca suggest that the body image is 'elastic', with women's perceptions of their body changing after watching less than 30 minutes of programming or advertising. They concluded that:

> television images that are fixated on the representation of the ideal female body immediately led the female subjects to thoughts about their own bodies. This in turn led to the measurable fluctuations and disturbances in their body image. In their mind's eye, their body shape had changed. (1992, p. 126)

Health psychologists recognize that body image is 'subjective and open to change through social influence' (Grogan, 1999, pp. 2–3), and

informed, changed or altered through feedback from friends, family and the media. At the same time, body image is treated as an individual property best examined at the individual level, and media influence is conceptualized and measured as if it is uni-directional. As such, the model is one in which outside pressures act upon the individual to influence an internally held model.

Assumption 4: that although a hypothetical construct, body image can be treated as real and accurately measured

Body image is assumed to be a relatively fixed and enduring phenomenon whose parameters require measurement. We consider here some of the ways in which methodological techniques are guided by, and in turn reinforce, particular theoretical conceptions of body image and in so doing close other approaches to research. Health psychologists assume that participants' responses to psychological measures make visible an internally held mental image of their own body. A number of conceptual and methodological issues arise from this assumption, which we discuss below.

1. It is necessary to simplify body image to make it operant and therefore approachable by standard psychological research techniques such as experimentation. Although many *definitions* approach body image as multi-faceted, it is largely examined experimentally as a uni-dimensional concept. The adjustable light beam apparatus, for example, treats the body as very simply imaged by allowing participants to manipulate the width of their body at only four points (waist, cheeks, hips and chest), and questionnaires measuring body dissatisfaction focus on limited areas of the body. For example, the Body Image Ideals Questionnaire asks respondents to rate physical characteristics on only eleven dimensions (Cash & Szymanski, 1995), although the Multidimensionsal Body Self-relations Questionnaire (Brown, Cash, & Mikulka, 1990) has a broader scope. Silhouette studies typically use a maximum of nine figures or silhouettes to capture the wide range of body size (e.g. Stunkard, Sorenson, & Schulsinger, 1983; Thompson and Altabe, 1991). This limited range of figures fails to capture differences in shape in terms of varying muscle development and fat distribution arising from genetic make-up and body use. Grogan (1999) demonstrates that the silhouette measure is compromised for the exploration of men's body image because it conflates muscularity and size and obscures the direction of dissatisfaction—for men being 'too thin' can be as problematic as being 'too fat' (see also Frith & Gleeson, 2004). The heterogeneity of body shape in relation to the ways in which fat is distributed to create different shapes is also overlooked. The larger figures are dominated by hanging flesh, the lines of the shoulders becoming softer as they are wrapped in fat but also narrower, as if the muscle necessary to support the larger body has disappeared. Recent innovations attempt to overcome these problems by exploring different ways of presenting images. Pope and colleagues (2000) have developed a computerized measure that allows for muscularity, as well as overall size ratings, while Stanford and McCabe (2002) use a computer program in which participants alter digital images of themselves. Health psychologists assume that body image could be accurately measured if only the appropriate technological means for making this internal image visible were available. Individuals are assumed to be conjuring up an image of their body (or ideal body) in order to compare it to an illustration provided by the researcher. Attempts to devise measures of body image work on the assumption that individuals are neutrally reporting facts about an internal image of their body that they hold 'in their heads'.
2. Not only is body image assumed to exist, but differences in participants' responses to psychological measures are assumed to represent 'real' differences in the ways they perceive or evaluate their bodies. Researchers assume that they can use silhouette figures to make judgements about how much dissatisfaction one person or social group has in relation to another. By focusing on a single dimension of the figures (e.g. size) scales appear to be separated by equal intervals—images are treated as if there is a

meaningful dimension along which they are spaced. The scale is treated as if it were a measure implying some degree of precision; a simple mapping of the symbolic language of the scale onto some ontological referent. It is unlikely that, for most people, one of the bodies on the scale will actually look like their own. Rather when choosing illustrations participants communicate about their understanding of what the gap between the illustrated bodies represents. How do participants make sense of the task that researchers set them? In the nine outline drawings of body shape, for example, do the boundaries reflect the cultural ideas about body shape? Where is the mid-point on that scale? Does it imply an average? In the language of scales where we go from 'most disagree' to 'most agree' do the two ends represent the extremes? In this case, they represent the extremes from a specific cultural standpoint, not the extremes in terms of viable living bodies. In a culture where 'you can never be too thin' participants may be describing their understanding of their place in the hierarchy of desired and valued body features rather than an evaluation of the actual proportion of their body.

3. Differences between actual and ideal body shapes are treated as if they are inherently meaningful. That is, they are interpreted as signifying dissatisfaction, regardless of whether or not such discrepancies are actually experienced as troubling. Tiggemann, Gardiner and Slater (2000) argue that there is an empirical question around the meaning of the figure preference rating scales favoured by body image researchers. Typically, girls choose as their ideal figure one which is significantly smaller than their current figure, and this discrepancy is taken as a measure of body dissatisfaction. Tiggemann et al. (2000) argue that the meaning or validity of this measure of body dissatisfaction is rarely questioned because the measure has been shown to have reasonable psychometric properties. To examine this they conducted focus groups with adolescent girls to explore the reasons they gave for wanting to be thinner. Girls indicated a range of reasons for wanting to be thinner including ideas that if they were thinner they would be more attractive, confident, receive more attention and be better able to fit into clothes. Girls also thought that they would be happier if they were thinner but their responses did not indicate that they were currently dissatisfied with their size. Therefore the choice of smaller body shapes in research does not necessarily imply dissatisfaction with current size.

Assumption 5: when responding to body image measures, people are neutrally providing information about an image that is held in their heads

Implicit in much research is that participants' responses are based on a neutral and objective examination of the internal image they have of their own bodies (i.e. their 'body image'), and compare this to the images they are presented with. This overlooks the social and cultural context in which cultural imperatives to look thin, be healthy and take responsibility for one's body dominate. For example, when women say that they would like to be thinner this may reflect what seems to be a sensible or acceptable answer to researchers' questions given the cultural imperative to be thin. Similarly, the cultural imperative to be wealthy means that few people would claim not to want to have more money. This does not necessarily mean that getting thinner is a major priority or that participants are motivated to engage in practices that will bring about thinness. It is unusual for health psychologists, in the course of presenting research about body image, to state clearly what they feel a healthy body should look like. However, both cultural imperatives and the assumptions of health psychologists hang heavy in the air when participants are asked to both describe their own and their ideal body image. Research on body image is dominated by a body ideal which, while implicit and not recognized, is sufficiently close to wider social norms, and sufficiently clear to research participants, that they give accounts of body image which they understand as 'counting' as appropriate accounts in the data collection context. It may be the case that people produce body image discrepancies in response to the demand characteristics of the research setting. For example, when using the silhouette drawings

are participants to assume that the mid-point represents the average, and could the average really be considered to be 'ideal'. Participants may not have a clear body ideal that they aspire to, they may simply be responding to social norms about how you might answer such questions. Consequently, researchers may be misperceiving the nature of the data elicitation task, and may certainly misunderstand what it is that their participants are doing while engaging in their research. Health psychologists who use the notion of body image are embedded within the same culture and presumably draw upon the same representations of ideal bodies. They are as much the 'victim' of unrealistic standards and ideal body 'fascism' as are their participants. This raises questions about what it is they do when health psychologists ask participants about body image, and the extent to which it can be assumed that participants can or do respond in neutral and objective terms in such research settings.

In sum, we argue that these five assumptions underpin the ways in which health psychologists typically research issues around body image. In the rest of the article we illustrate some of the problems which arise from this reified, schema-driven, individualized notion of body image, and the way in which this constrains the kinds of questions addressed by health psychologists before outlining an alternative approach based on body-imaging.

The problems with 'body image'

One way in which health psychology can avoid the worst consequences of a reified, schema-driven, individualized notion of body image, is to treat the assumptions that underpin such an approach as a series of problems for us in re-thinking body image.

Problem 1: the 'body image' construct narrows the focus of researchers

Health psychology has employed the notion of body image to examine a range of issues, especially people's troubled and troubling relationships with their body. It is our argument that research could also benefit from an opening up of space within which to explore the relatively mundane and ordinary thinking about the body in all its complexity and diversity. A reification of the body image construct, and the heuristic benefits of a consensual model of body image has pragmatic value in so far as it allows us to capture some of the issues surrounding apparently nonsensical health-related and dietary behaviours. However, there are problems with conceptualizing body image as a mental representation that exists inside the individual, which can be accurately measured using perceptually based techniques. The assumption that 'body image' is an explanatory factor in behaviour and psychological functioning guides our research questions and narrows our research focus. What factors influence body image? How can we accurately measure changes in body image? How does body image relate to psychological functioning such as body dissatisfaction? How can we influence and change body image? The focus on procedures for answering these questions means that less interest is paid to the diversity of people's experiences and understandings of their bodies, and how people use these understandings in their everyday lives and in their interactions with others. It is possible to consider broader questions about how people make sense of their embodied experience and to raise questions about whether body image is the only, or indeed the best, way to explain the patterns of behaviour problematized by health psychology. We could broaden our focus, not to abandon the useful work on 'pathological' responses to embodied experience, such as eating disorders and dysmorphias, but to encompass these within the range of everyday routine experiences with and understandings of the body. We could apply this focus on the routine to incorporate the diversity in body shape, size and function and within this include disability and difference.

Problem 2: the 'body image' construct downplays the contextual nature of body image

Understanding body image as a pre-formed mental representation that remains relatively static across situations is also problematic because it overlooks the inherently socially embedded nature of embodiment. While there is a recognition of the importance of the social

and cultural in the 'development' of a body image, this negotiation and constructive activity is implicitly embedded in past events—body image is a product of *past* experience and social interaction. One of the consequences of designing research based on an assumption that body image is the enduring property of an individual entails ignoring the interpersonal and collective work which people do in making meaning of their own bodies and the bodies of others. Merleau-Ponty (1962) asserts that the body is never isolated and singular, it is always already engaged with the world, even when physically separated from the company of others. The different aspects and parts of the body, and the various ongoing experiences of embodiment are pulled together into something resembling a representation of the body image only 'in proportion to their value to the organism's projects' (Merleau-Ponty, 1962, p. 100). This suggests that the individualized location of body image may limit health psychology's attempts to address the complexities of the socio-cultural origins of body image. Weiss's (1999) insightful development of Merleau-Ponty's work makes the inevitability of the social body clear. She asserts that our identity projects 'derive their significance not merely from an individual's intentions, but from the situation out of which they have emerged and in which they are expressed' (Weiss, 1999, p. 1). In research exploring men's relationship to their bodies (Frith & Gleeson, 2004) we found that men experience their bodies in context-specific ways. Different elements of the body such as height, musculature and adipose tissue become salient and are responded to in different ways depending on the social, physical, cultural, temporal and spatial contexts in which they are operating. For example, the same legs become a source of pride, regret, fear, loathing or indifference in different physical or imagined contexts. Other researchers have found that the additional weight that most women eschew in most contexts, becomes acceptable in the context of pregnancy (Johnson, Burrows, & Williamson, 2004). In taking body image out of these contexts in order to study and measure its parameters, psychologists miss the complexity and fluidity of the ways in which individuals perceive and evaluate their bodies.

Problem 3: the 'body image' construct de-emphasizes the discursive production of body image

Assuming that body image 'exists' means that we forget to ask important questions about how this construct comes into being, and how it is deployed and given meaning in everyday health-related contexts. Ceasing to treat body image as a 'real' thing that can be measured and objectively reported, enables us to observe its discursive production, that is to examine how people actively use body image to achieve certain ends, justify particular actions and manage particular identities. Research participants are active and self-reflexive, and participate (or not) in health-related practices within the context of a 'scopic economy of body capital' in which some bodies are more highly valued than others (see Skeggs, 2001), and a context in which we are morally obliged to 'look after ourselves' (Crossley, 2003; Guttman & Ressler, 2001; Martin, 2001). This context is reflected in our own research practice in which the attempts of participants to answer our questions can be understood in relation to how they are called to account for their actions, rather than as merely reflecting the means by which they guide, motivate and reflect upon their experience. Addressing the ideological and conceptual messages that are communicated to research participants enables a more reflexive approach to research and allows the examination of body image as a conceptual device constructed through negotiation between the researcher and researched as well as between the different members of a culture. Being reflexive about research processes opens up issues about the position of researchers within this cultural and ethical framework. The dialogical analysis of people's strategic use of body image may help us to understand the ways in which the messages provided by health psychologists impact upon everyday behaviour and understanding, and the ways in which their effectiveness is mediated.

Problem 4: the 'body image' construct elides the social nature of perception

By assuming that body image is a mental representation formed through uni-directional perceptual processes health psychologists

overlook the inherently social and constructed nature of perception. Individuals learn to recognize and perceive the world as well as to name and speak about it. This perception involves learning where to focus our attention, how to gauge, judge and compare. In its neutrality, the language of perceptual processes obscures from view the cultural shifts and changes about what key aspects of the body it is considered meaningful to attend to and measure in terms of body shape. The components of the body that are recognized, and regarded as measurable, have changed over time: reflecting on the waist rather than the ankles or the fingers gives a sense of the cultural norms regarding the key features that might be incorporated into body image. Although women report that they wish to look slimmer than their current shape, their decisions about body size take into account a whole range of different features that vary with size. Women may be happy with larger hips if they also have bigger breasts, or a larger body may mean a fuller face and less scrawny neck. While most women take on the cultural imperative to thinness, some prioritize other aspects of appearance. While satisfaction may be an important aspect of how we experience our bodies, it is a fairly gross measure and does not provide much information about how people use their body image to construct strategies and behaviours.

Problem 5: the 'body image' construct distracts from the dialogic nature of body image

By assuming that body image is an internal and individual mental representation of the appearance of the body, there is less interest in the dialogic nature of individuals' engagement with the body and the social contexts in which the body is understood. In contrast to much research in communication studies, health psychologists tend to assume, for example, that media influence on body image is uni-directional and implicitly causal, with images of thin models in magazines being a cause of body dissatisfaction in young girls. However, collective opposition to distorted and narrow definitions of female beauty in magazines is often voiced in young women's talk. For example, although the girls in Currie's (1997, 1999) study enjoyed the magazines they read and compared themselves to the models, they also criticized the use of unrealistic and 'too perfect' representations of girls and women. Another important challenge comes from research that shows that people are active readers/viewers of the media, use images for their own pleasures and to create their own meanings (Hollows, 2000). They may resist or simply not take up the more dominant meanings offered by media images, such as, the notion that thin is beautiful or good, or that to be beautiful one need be white. For example, Duke (2002) found that although African American girls recognized the cultural codes of (white) femininity contained in the magazines they read, they rejected the messages as 'unreal' and unrepresentative of their own experiences: 'African American girls felt White magazine models who were very thin or made up were not attractive; that diet products were not essential or even desirable for Black girls to look their best' (Duke, 2002, p. 223). Duke is arguing that the influence of culture is complex with young women actively engaged in identity projects and contributing to the production of their own and each other's embodiment. People modify and resist the messages and feedback they receive about their bodies, and negotiate their positions while simultaneously monitoring self and monitoring the feedback from others. A dialogical model such as this could facilitate the attempts of health psychology to explain the ways in which people resist, avoid and manage the messages that they are given about health and healthy behaviour.

Problem 6: the 'body image' construct encourages researchers to individualize body concerns

While acknowledging the role of socio-cultural factors in the development of body image, and incorporating social causes into individual pathology, health psychologists, nevertheless, tend to separate the individual from the social. The social is used to explain the individual's behaviour but the processes whereby the individual engages and exchanges with the social remain largely unexplored (e.g. Neumark-Sztainer, Wall, Story, & Perry, 2003). This neglect is based on an assumption that while the individual's interaction with the social may be important, it is so complex that it is unrealistic to expect the individual to be able to challenge

the dominance of body ideals in the media. However, the prospect of an individual tackling their own erroneous body image, at least therapeutically, appears a much more realistic option. As interventions focus on changing the erroneous individual, rather than the problematic society, or their relationship to a problematic set of cultural ideals, then the assumption that an image of the visual appearance of the body is necessarily and inevitably internalized remains unchallenged. Health psychologists avoid the imperative to tackle media representations which lead to a socially shared, but almost impossible to achieve, image of the ideal body. People might all be suffering from more or less the same 'delusion' but the way to deal with it is individual by individual. Even though health psychologists use the media in all its forms for health promotion, the understanding of how individuals consume the media, particularly in relation to how they use it to inform health practices, is in its infancy. There is valuable research yet to be done into the processes whereby people identify with and incorporate health messages into their practice. Health psychologists might learn from those in media studies who engage in media literacy training to teach young men and women how to subvert the media messages (e.g. Bergsma, 2004; Wade, Davidson, & O'Dea, 2003).

Body imaging—a way forward for health psychology

Rather than using the static notion of the body image schema, we argue that it is more useful to consider *body imaging* as a process, an activity, rather than a product. An example of the small body of research in this area is Cash's (2002) research, which illustrates the value of understanding body image in relation to a series of strategic activities with the physical self. While still a social-cognition model, which refers to 'schema-driven processing of information about, and self-evaluations of, one's physical appearance', Cash (2002, p. 42) suggests that we understand that processing in relation to a range of self-regulatory activities. Cash's research *incidentally* supports the notion that appearance is continually created by the individual. We feel this requires us to abandon body-image-as-schema in order to consider body-imaging as an active process which the individual engages in to modify, ameliorate and come to terms with their body in specific temporal and cultural locations.

An as yet limited, but growing number of studies that use reflexive, qualitative and experiential paradigms are beginning to develop the concept of body image in ways that are more complex and dynamic rather than reified, static and schema driven. For example, Choi (2000) has explored the relationships between exercise, appearance, identity and femininity, attempting to focus on the complex interplay between physical activity in the production of the self rather than merely as a route to a healthy body. Johnston, Reilly and Kremer in a grounded theory lifespan study of women's experiences of appearance concern and body control highlight the value of a qualitative approach which avoids dependence on 'simple and sovereign factors determining an individual's levels of appearance concern or body control' (2004, p. 397). Finally, Grogan, Evans, Wright and Hunter (2004) conducted interviews with female bodybuilders and described the 'balancing act' they performed between muscularity and femininity in meeting the complex demands of those within and outside of the body-building community.

Good research that addresses body image must capture the individual's active engagement with the interplay between embodied experience, identity and display. Rather than using the static notion of the body image schema, we suggest that it is more useful to consider body imaging as a process, an activity rather than a product. Body imaging incorporates a series of judgements, perceptions, negotiations, contests and reflections. Body imaging is one of the tasks that individuals might engage in while participating in research, and also while reflexively working on their own identity. The explanations for apparent discrepancies between behaviour and body shape and size will not be explained without recourse to the complexity of the multiple negotiations that individuals engage in. A fresh starting point that embraces the complexity of reflexive experience will open up a new fruitful avenue for health psychology's exploration.

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